	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Medical Director,** **Shire Lodge Nursing Home,** **281 Rockingham Road,** **Corby, NN17 2AE**
1	**CORONER** I am Anne Mary Christine Pember, Senior Coroner for the coroner area of Northampton.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 30th July 2012 I commenced an investigation into the death of Beatrice Wright Herriot Gatt aged 69 years. The investigation concluded at the end of the inquest on 3rd September 2014. The conclusion of the inquest was: **Beatrice Wright Herriot Gatt was a patient at Shire Lodge Nursing Home. Due to an error her anti-psychotic clozapine medication was not given on 6th, 7th and 8th May 2012.** **Subsequently her mental state deteriorated and she was transferred to the Welland psychiatric unit. There she suffered two falls, fractured her hip and was conveyed to Kettering General Hospital for surgery.** **She later returned to the Welland Centre where she was found on 18th July on the floor. She was confirmed deceased at Kettering General Hospital later that day. The cause of her death was:-** **1 a) Gastrointestinal haemorrhage** **b) Duodenal ulcer** **It cannot be confirmed that there was a causal connection between the cessation of clozapine, her falls (fracture) and subsequent death.**
4	**CIRCUMSTANCES OF THE DEATH** On the 18th July 2012 the deceased was discovered unresponsive at her home address. She was taken to Kettering General Hospital but treatment was unsuccessful and her death was confirmed at 06.46 hours.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1) Mrs Gatt was not given her anti-psychotic clozapine medication due to an error in the medication not being transferred from 1 Mars sheet to another. There did not appear to be any formal training of nursing staff as to how the Mars sheet

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **13th November 2014**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. I acknowledge receipt of an interim report from your Trust received four days before the inquest.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-. [redacted] **(Wilson Browne Solicitors) for** [redacted] [redacted] **(Hempsons Solicitors) for NHS Northamptonshire Trust.** [redacted] **(Keoghs Solicitors) for Shire Lodge Nursing Home.** [redacted] **(Safeguarding Adults Team Northamptonshire Council)** Similarly, you are under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**[DATE]** **[SIGNED BY CORONER]** **18th September 2014**